RSC Republican Study Committee
Rep. Jeb Hensarling (R-TX), Chairman
Russ Vought, Executive Director
132 Cannon House Office Building
Washington, DC 20515
www.house.gov/hensarling/rsc
ph (202) 226-9717 / fax (202) 226-1633

RSC Policy Brief: Certificate of Need Programs

May 13, 2008

The RSC has prepared the following policy brief analyzing state Certificate of Need programs and their impact on health care policy.

History and Background: In the 1960s, some health care policy makers began to believe that an excess supply of providers was having an inflationary impact on the price of health care. As a result, several states, beginning with New York in 1964, enacted "certificate of need" (CON) laws giving state agencies the power to evaluate whether a new hospital or nursing home facility was needed prior to its construction. Prompted in part by support from the American Hospital Association, 20 states enacted certificate of need laws by 1975.[1]

In January 1975, President Ford signed into law the National Health Planning and Resources Development Act (P.L. 93-641), originally sponsored by Sen. Ted Kennedy (D-MA). The Act provided incentives for states to enact approval mechanisms prior to the construction of major facilities. As a result, by 1980 all states but Louisiana had established CON programs.[2] However, Congress enacted legislation (P.L. 99-660) repealing the federal law in November 1986, which in time led 14 states to abolish their certificate of need programs. Nevertheless, 36 states and the District of Columbia maintain some form of restriction on the construction of new medical facilities absent a determination of necessity.

Changes within the Hospital Industry: In the more than four decades since the first certificate of need program was established, the hospital industry has undergone numerous changes and consolidations that may be seen as undermining the original rationale for the certificate of need mechanism. At the time certificate of need laws were enacted, most hospitals received cost-

[1] "Certificate of Need State Laws 2008," (Washington, DC, National Council of State Legislatures, updated May 8, 2008), available online at http://www.ncsl.org/programs/health/cert-need.htm (accessed May 11, 2008).
[2] Cited in *Improving Health Care: A Dose of Competition* (Washington, DC, Department of Justice and Federal Trade Commission Joint Report, July 2004), available online at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf (accessed May 11, 2008), p. 301.

based reimbursement for services from both the federal government and private insurers. This payment mechanism, when coupled with a perceived lack of incentives for consumers to become cost-conscious about their health care expenditures, led policy-makers to impose external restrictions on providers' growth (in an attempt to slow the growth of health expenditures) due to a belief that they would fail to compete on price grounds.[3] However, the intervening decades have seen a move away from cost-based reimbursement and toward prospective payment for procedures, along with greater incentives—higher deductibles, Health Savings Accounts, co-insurance, etc.—for consumers to demonstrate price sensitivity in health care. Thus the economic conditions which led regulators to impose certificate of need restrictions have changed appreciably for both consumers and providers, which may prompt a re-evaluation of their usefulness and efficacy.

In addition, a wave of consolidation within the hospital sector has attracted the attention of antitrust regulators, who have examined the impact of hospital mergers on health care. As of 2001, nearly 54% of hospitals nationwide had joined a larger hospital system, with a further 12.7% working in looser affiliations. Combined, two-thirds of hospitals nationwide (66.7%) participated in some form of network or system affiliation—more than double the 31% two decades previously, in 1979.[4]

In 2004, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) conducted a series of fact-finding hearings that culminated in a joint study analyzing the antitrust implications of health care policy, which featured several chapters specifically devoted to the changes within the hospital industry.[5] Reports submitted to the panel cited the "extensive consolidation" within the health care industry, "at times creating virtual monopolies in geographic submarkets" that allowed hospitals to "exert greater leverage in managed care contract negotiations" while pressuring physicians to join a particular system.[6] Other witnesses noted the way in which hospital systems attempt to include at least one "must have" hospital in each geographic market, which will allow the system to demand price increases.[7]

Both the FTC-DOJ report and other independent studies have noted the link between high levels of consolidation within the hospital industry and higher prices. Best estimates indicate that hospital mergers tend to increase prices from 5-40%—while also resulting in decreases in quality.[8] A National Bureau of Economic Research working paper found that, by resulting in a loss of consumer surplus of $42.2 billion over a decade (most of which went to providers),

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[3] Ibid., pp. 302-303.
[4] Ibid., pp. 133-134.
[5] Background information, agendas, and transcripts for the hearings can be found online at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm (accessed May 12, 2008).
[6] Cara Lesser and Paul Ginsburg, "Back to the Future?: New Cost and Access Challenges Emerge," (Washington, DC, Center for Studying Health System Change Issue Brief No. 35, February 2001), available online at http://www.hschange.com/CONTENT/295/ (accessed May 11, 2008).
[7] Cited in *Dose of Competition*, p. 138.
[8] William Vogt and Robert Town, "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" (Princeton, NJ, Robert Wood Johnson Foundation Research Synthesis Project No. 9, February 2006), available online at http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no9_researchreport.pdf (accessed May 12, 2008), pp. 8-10.

hospital mergers had the net effect of raising insurance premiums 3-5%, thus ***increasing the number of uninsured*** by almost 5.5 million life-years from 1990 through 2003.[9]

Effect of CON on Competition, Price, and Quality: Conservatives who believe in free markets may not object to consolidation within the hospital industry, or any other industry, provided that no other external factor interferes with the operation of the economic market. However, if the market has been distorted through public policy actions by legislators—as in the case of the 36 states and the District of Columbia with certificate of need laws—some conservatives may view such laws with caution, due to the potential negative implications which a state-granted oligopoly for existing providers may have on the ability of new entrants to improve the health care marketplace through innovative practices and techniques.

The same FTC-DOJ report that noted the correlation between hospital consolidation and rising prices also criticized the state certificate of need model as anticompetitive and not in consumers' best interest. Witnesses testified that the barriers to entry presented by certificate of need requirements impeded rapid implementation of new health care technologies, with significant adverse effects on overall health care spending—rising prices due to more limited access to care, and/or re-directing spending to other areas of health care (i.e. a restriction on development of new beds leading to increased investment in radiological or other equipment).[10] The report concluded:

> The Agencies believe that CON programs are generally not successful in containing health care costs and that they can pose anticompetitive risks….CON programs risk entrenching oligopolists and eroding consumer welfare. The aim of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks.[11]

Because of the "serious competitive concerns" that outweighed the purported benefits, the agencies advised states to re-evaluate whether their certificate of need programs in fact serve the public good.

In addition to the impact of certificate of need programs on price and market penetration, the stubbornly high rates of medical errors and hospital-acquired infections may be symptomatic of quality control difficulties rooted in a lack of competition. The 1999 Institute of Medicine study *To Err Is Human* estimated that between 44,000 and 98,000 Americans die annually in hospitals due to preventable medical errors, creating a total economic cost of as much as $29 billion, and a November 2006 report utilizing data from a new infection-reporting regime in Pennsylvania found 19,154 cases of hospital-acquired infections in 2005 alone, representing an infection incident rate of more than 1 in 100 hospitalizations.[12] With consolidation having eroded the

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[9] Robert Town *et al.*, "The Welfare Consequences of Hospital Mergers," (Cambridge, MA, National Bureau of Economic Research Working Paper 12244), available online at http://www.nber.org/papers/w12244.pdf?new_window=1 (accessed May 13, 2008), Tables 8-10, pp. 48-50.
[10] See ibid., pp. 301-306.
[11] Ibid., p. 306.
[12] Institute of Medicine, *To Err Is Human: Building a Safer Health System*, summary available online at http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf (accessed March 1, 2008); Pennsylvania Health

breadth of competing hospitals in some markets, and state certificate of need programs presenting a significant barrier for potential new entrants, the prime driver of quality improvement within the hospital sector may be fear of litigation—a process which some conservatives may find economically inefficient and poor public policy.

The impact of certificate of need programs on quality improvements was illustrated in data from an October 2003 Government Accountability Office (GAO) study examining physician-owned specialty hospitals. According to GAO, 83% of all specialty hospitals—and all specialty hospitals then under development—were located in states without certificate of need requirements.[13] The FTC-DOJ study also cited the example of a Florida law enacted in 2003, which barred single-practice specialty hospitals while simultaneously eliminating certificate of need requirements for various cardiac programs at general hospitals.[14] Some conservatives may therefore be concerned first that the innovation and quality improvements which physician-owned specialty hospitals have introduced are being denied to residents in many states due to certificate of need restrictions, and second that this archaic and bureaucratic mechanism has become a political football that existing facilities attempt to manipulate in order to maintain existing oligopolies.[15]

Security Impact: The September 11 attacks and subsequent concerns regarding incidents of mass terrorism, bioterrorism, or pandemic outbreaks have raised the prominence of the need for "surge capacity" in the event of a major public health disaster. Although such surge capacity need not be located within the confines of a hospital, specialized medical centers may play a significant role in any response to a large-scale incident.

On May 5 and 7, 2008, the House Committee on Oversight and Government Reform held hearings regarding a potential lack of hospital surge capacity.[16] Chairman Henry Waxman (D-CA) attempted to assert that the implementation of several proposed Medicaid anti-fraud regulations would compel hospitals to reduce or eliminate trauma centers whose services would be needed in the event of a major terror incident. In response, Secretary of Health and Human Services Mike Leavitt noted that the need for proper public health capacity to respond to terrorist incidents should not impede the Administration from enacting reasonable controls to ensure that the Medicaid program meets its statutory goal of providing health care to low-income individuals, as opposed to serving as a bioterror response agency.

In addition to agreeing with the Secretary's assertion that the distinction between public health preparedness and implementation of Medicaid anti-fraud regulations saving $42 billion over a

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Care Cost Containment Council, *Hospital Acquired Infections in Pennsylvania*, available online at http://www.phc4.org/reports/hai/05/docs/hai2005report.pdf (accessed March 1, 2008).

[13] "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," (Washington, Government Accountability Office, Report GAO-04-167), available online at http://www.gao.gov/new.items/d04167.pdf (accessed May 11, 2008), pp. 20-21.

[14] Cited in *Dose of Competition*, p. 146, note 116.

[15] The Center for Responsive Politics notes that from 1998 through March 2008, the hospital and nursing home industry spent more than $610 million on federal lobbying alone, placing it ninth among 121 industry categories. Data available online at http://www.opensecrets.org/lobby/top.php?indexType=i (accessed May 12, 2008).

[16] Information about the hearings can be found at http://oversight.house.gov/story.asp?ID=1929 (accessed May 10, 2008).

decade is a false dichotomy, some conservatives may also believe that a better way to increase "surge capacity" in 36 states and the District of Columbia would involve a repeal of certificate of need restrictions. Rather than maintaining bureaucratic regulations that prevent construction of health care facilities of critical importance in a mass-casualty incident—or jeopardizing existing physician-owned trauma centers by enacting new restrictions on physician ownership, as House Democrats have proposed—conservatives may believe that a better alternative would allow free markets to innovate and create new medical centers should capacity for trauma units or other segments of care be lacking in a particular market.

Conclusion: Proposals to expand the government's role in health care have frequently been criticized by conservatives as the first step towards rationed care. However, some conservatives may use the certificate of need model to argue that 36 states and the District of Columbia ***already ration health care***, by limiting the ability of new entrants to provide medical services to their citizens. For instance, the recent decision of the Michigan Certificate of Need Commission to limit the number of new radiation facilities in the state may have an adverse impact on cancer patients seeking access to a novel form of treatment.[17]

With a McKinsey group study noting that hospitals account for 50% of the excess spending in American health care relative to other countries, some conservatives may argue that the hospital industry in particular warrants the additional innovation and reduced costs which new entrants can provide.[18] Congress itself recognized this fact in 1980 by passing legislation (P.L. 96-499) making ambulatory surgery centers (ASCs) eligible for Medicare reimbursement, believing that new ASCs could perform certain medical procedures more cost-effectively than general hospitals.[19] Yet the exhaustive FTC-DOJ study, as well as related literature, have documented the ways in which state-based certificate of need laws have undermined market-based efforts at cost control—by resulting in less competition, higher prices, and a diminished emphasis on quality that new market entrants can elicit. In addition, the changed environment of a post-9/11 world raises questions as to whether states with certificate of need programs are denying to their citizens facilities that could be of critical importance in a public health crisis. Viewed from these perspectives, the certificate of need model may look less like an effective mechanism to contain the growth of health care costs than an outdated shibboleth that ultimately harms the citizens whom it was designed to protect.

Some conservatives may believe that the nearly 100,000 deaths annually due to preventable medical errors constitute proof positive that the certificate of need model should be permanently dismantled, and that the billions of dollars in hospital expenditures made by the federal government may warrant a federal role in persuading recalcitrant states to do so. This fiscal year alone, the federal government will spend at least $27.1 billion on payments to hospitals not directly attributable to patient care—including Medicare and Medicaid disproportionate share

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[17] Andrew Pollack, "States Limit Costly Sites for Cancer Radiation," *New York Times* May 1, 2008, available online at http://www.nytimes.com/2008/05/01/technology/01proton.html?_r=2&adxnnl=1&8br=&oref=slogin&adxnnlx=1210543656-RJG4oNSF434Dh4b52KfeFA&pagewanted=print (accessed May 11, 2008).

[18] Cited in Regina Herzlinger, *Who Killed Health Care? America's $2 Trillion Medical Problem—and the Consumer Driven Cure* (New York, McGraw-Hill, 2007), p. 62.

[19] Cited in *Dose of Competition*, p. 148.

hospital payments, and graduate and indirect medical education costs.[20] Some conservatives may therefore support policies intended to link some or all of these payments to states' repeal of certificate of need laws, in the belief that the abolition of such measures will improve competition, drive down prices, and enhance the quality of health care nationwide.

For further information on this issue see:

- *Federal Trade Commission/Department of Justice Report: Improving Health Care: A Dose of Competition*
- *National Council of State Legislatures: Certificate of Need State Laws, 2008*
- *RSC Policy Brief: Specialty Hospitals*

RSC Staff Contact: Chris Jacobs, christopher.jacobs@mail.house.gov, (202) 226-8585

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[20] Congressional Budget Office March 2008 baselines for Medicare and Medicaid, available online at http://www.cbo.gov/budget/factsheets/2008b/medicare.pdf and http://www.cbo.gov/budget/factsheets/2008b/medicaidBaseline.pdf, respectively (accessed May 12, 2008).